MHS Professional & Facility Billing 2019

Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect

Agenda

- MHS Overview
- Claim Submission Process
- Common Rejection Errors
- Claim Denials & Problem Solving
- Adjustments & Timelines
- Prior Authorization
- Dispute Resolution Process
- Web Portal Functionality
- Professional Billing
- Facility Billing
- MHS Team
- Summary
- Questions

MHS Overview

Who is MHS?

Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for two decades through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.

MHS is your choice for better healthcare.

MHS Products

Claim Submission Process

Medical Claim Submission

- **Electronic Data Interchange Submission:**
  - Preferred method of claims submission
  - Faster and less expensive than paper submission
  - MHS Electronic Payor ID **68069**
- Online through the **MHS Secure Provider Portal** at mhsindiana.com:
  - Provides immediate confirmation of received claims and acceptance
  - Institutional and Professional
  - Batch Claims
  - Claim Adjustments/Corrections
- **Paper Claims:**
  Managed Health Services
  PO Box 3002
  Farmington, MO 63640-3802

Behavioral Health Claim Submission

Electronic Submission:
- Payer ID 68068
- MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange
- It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payer Reject Report)

Online Submission through the **MHS Secure Provider Portal:**
- Verify Member Eligibility
- Submit and manage both Professional and Facility claims, including 937 batch files
- To create an account, go to: mhsindiana.com

Paper Claims:
- MHS Behavioral Health
  PO Box 6800
  Farmington, MO 63640-3818

Claim Inquiries:
- Check status online
- Call Provider Services at 1-877-647-4848

Transportation Claims

- Beginning with dates of service May 1, 2019 and after, Managed Health Services (MHS) will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance, which would have previously been processed by LCP Transportation.

- Claims for the following services should be sent to MHS starting with date of service May 1, 2019:
  - 911 Transports
  - Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).
  - Air ambulance

- Only providers enrolled with the Indiana Health Coverage Programs (IHCP) are eligible for reimbursement. Claims must be filed within 180 days of the Date of Service date of service for non-contracted providers and within 90 days of DOS for contracted providers.

- Claims should be submitted to MHS via a CMS-1500 professional claim form. Claims may be submitted via EDI (preferred), MHS web portal or paper.

Transportation Claims

- MHS will follow IHCP billing guidelines for coding and reimbursement.

  For more information on Medicaid ambulance billing guidelines, please visit in.gov/medicaid/files/transportation%20services.

- **Claim Inquiries**:
  - Check status online
  - Call Provider Services at 1-877-647-4848

Claim Submission

Timelines:

👪 21 days for electronic clean claims

👪 30 days for paper clean claims

👪 Before you resubmit, check the claim status via the portals. If there is no record of the claim, resubmit.

Note: A "clean claim" is one in which all information required for processing the claim is present.

Claim Submission

- Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.
- Exceptions:
  - Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborn's RID #.
  - TPL – Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary Explanation of Benefits. If primary EOB is received after the 365 days, providers have *60 days* from date of primary EOB to file claim to MHS. If the third party does not respond within 90 days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patients primary.

Claims Submission

Claim Acceptance & Adjudication

- System reviews claim for errors and critical fields (i.e. dates of service, billing/rendering provider, etc.) prior to acceptance.

- Regulatory requirements (federal and state) mandates certain information to be present in order to accept and pay a claim.

- NPI common rejection/denial; provider information on claim **must** match record at IHCP enrollment – a State requirement.

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Claims Submission

Resubmissions:

- Electronic adjustments through the web portal
- Hard copy resubmissions:
  - Adjustment option on the MHS website
  - Must attach Explanation of Payment, documentation, and explanation of the resubmission reason
  - May use the Provider Claims Adjustment Request Form
- Providers have **67 calendar days** from the date of Explanation of Payment file a resubmission.

Please note, claims will not be reconsidered after this timeline.

EFTs and ERAs

MHS uses Payspan Health for:

- Web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- One year retrieval of remittance advice
- Provided at no cost to providers and allows online enrollment
- Register at payspanhealth.com:
  - For questions call 1-877-331-7154 or email providersupport@payspanhealth.com

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Common Rejection Errors

Claims Submission

Claim Rejection

- A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.

Timely filing is not substantiated.

Rejected claims may be corrected and resubmitted.

Examples of rejected claims

- Provider/practitioner not enrolled in IHCP
- Invalid member RID number
- Incorrect type of bill for the service or location
- Missing or invalid modifier

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Claim Rejections

EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.

Paper to electronic mapping is available on mhsindiana.com/provider-guides.

MHS website tools :

- Reject code listing
- Refer to top 10 rejection code help aid document

Common Claim Rejections

- **B1** - *Rendering and Billing NPI are not tied on state file:*
    - The rendering providers NPI is not linked to the billing address on the Indiana Health Coverage Programs (IHCP) portal.

- **B2** - *Not enrolled with MHS with rendering NPI/TIN/Program on date of service:*
    - Enroll with MHS and resubmit

Common Claim Rejections

Incomplete or invalid member information:

- o **07 REJECTION**: *Invalid Subscriber/Member ID*
- o **08 REJECTION**: *Invalid Member Date of Birth*
- o **09 REJECTION:** *Member Invalid on Date of Service*

- Please verify the member's eligibility via the IHCP Provider Healthcare Portal.

- If you believe the member information is correct, please call 1-877-647-4848 to speak with an MHS Provider Services Representative.
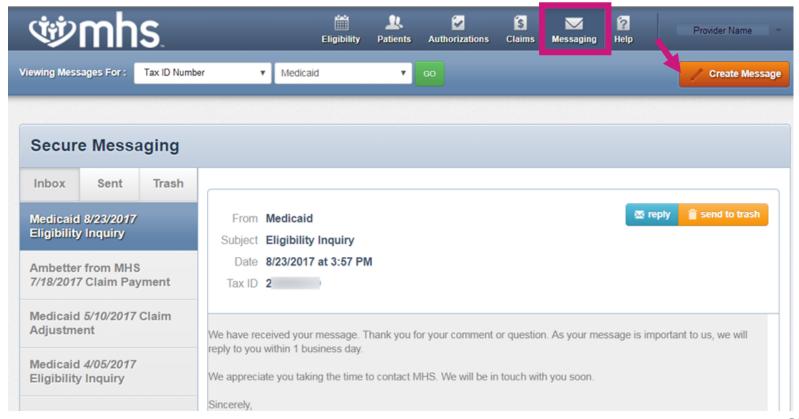
Claim Denials & Problem Solving

Claim Research Steps

STEP 1. Review claim on MHS Secure Provider Portal:
- mhsindiana.com/provider/login
- Secure message option
- Exercise Dispute Resolution Rights (refer to process)

STEP 2. Contact MHS Provider Inquiry Customer Service 1-877-647-4848

STEP 3. Utilize the Provider Relations Inquiry email address:

Secure Messaging

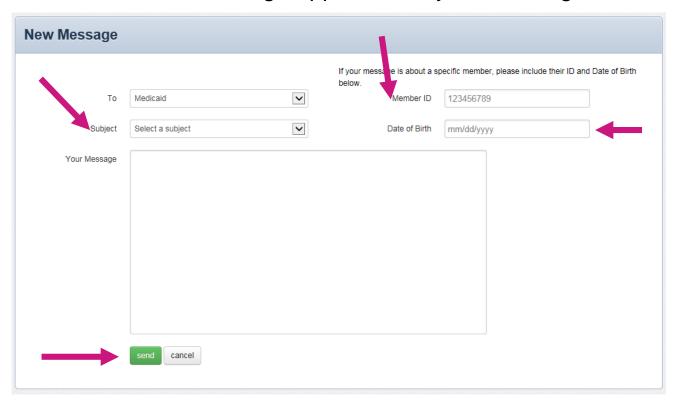Create a **New Secure Message:**

- Click **Messaging** tab from the Dashboard.
- Click **Create Message.**

Secure Messaging

Contents of a Secure Message:

- Select **Subject** and if applicable **Member ID and Date of Birth** along with your message then click **Send.**
- A confirmation message appears that your message successfully sent.

Top 5 Claim Denials for 2019

1. Time Limit For Filing Has Expired (EX29)
2. Bill Primary Insurer 1st (EXL6)
3. Authorization Not On File (EXA1)
4. Denied After Review of Patients Claim History (EXya)
5. Invalid or missing modifier (EXIM)

Additional Information for Denial Codes can be found using this link

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/0917-OS-P-WM-EX-Code-Descriptions-MHS-Denial-Codes-11-17-2017.pdf

Common Claim Denials

Time Limit For Filing Has Expired (EX29):

- Claims must be received within **90 calendar days** of the date of service (contracted providers).

- Claims must be corrected within **67 days** of the EOP date.

Bill Primary Insurer 1st (EXL6):

- Verify other insurance (TPL). Medicaid is the payer of last resort.

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Common Claim Denials

Authorization Not On File (EXA1):
- Prior Authorization should be requested at least two (2) business days prior to the date of service.
- All urgent and emergent services must be requested to MHS within two (2) business days after service/admit.
- Authorizations can be updated within 30 days from date of service.

Qualifier, National Drug Code (NDC) Number, Unit Of Measure Required (EX N5):
- As of January 1, 2012, providers must submit the product NDC, the NDC unit of measure (UOM), and NDC quantity of units, along with the procedure code, when submitting claims to IHCP MCEs for certain procedure-coded drugs.
- A list of the procedure codes that require NDCs is located on indianamedicaid.com (this list is updated quarterly).

Common Claim Denials

⚕️ National Drug Code information missing or invalid:

- Services requiring National Drug Code must be billed with valid National Drug Code numbers in the correct format:
  - Enter the National Drug Code qualifier of N4
  - Enter the National Drug Code 11 digit numeric code
  - Enter the drug description
  - Enter the National Drug Code unit qualifier of F2 for international unit, GR for gram, ML for milliliter, ME for milligram and UN for units
  - Enter the National Data Center quantity (administered/billed amount) in the formation of 9999.99

Common Claim Denials

- **Not an Managed Care Entity (MCE) Covered Benefit (EX50):**
  - Service must be covered by Indiana Medicaid
  - Carved out services not paid by MHS
- **Member Name/Number/Date Of Birth Do Not Match (EXMQ):**
  - Member information on claim must match what is on file with Indiana Medicaid.
- **Modifier Missing or Invalid (EXIM):**
  - Certain CPT codes require modifiers in order to be processed.
    - i.e. deliveries must be billed with either modifier UA, UB or UC

Common Claim Denials

- **Denied After Review of Patients Claim History (EXya):**
  - National Correct Coding Initiative (NCCI):
    - Developed by the Centers for Medicare and Medicaid Services
    - Policies were developed using American Medical Association (AMA's) Current Procedural Terminology (CPT) guidelines, national professional association's recommendations, and common coding practices.
  - MHS utilizes HealthCare Insight (HCI) for NCCI reviews:
    - Denials are issued by a clinician.
  - Guidance and resources are available on cms.gov

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Claim Billing with Ease

- **NPI, Tax ID, Zip +4**
- This information is necessary for the system to make a one to one match based off of the information provided on the claim and the information on file with Indiana Medicaid.
  - Member Information
  - Newborn's RID number is required for payment
- **Attachment Forms:**
  - Required forms need to accompany the claim form
- **Secondary Claims (TPL):**
  - Accepted electronically from vendors or via the MHS Secure Provider Portal

Adjustments & Timelines

Claim Process

Claim Adjustment

- A claim adjustment code is required on all claims, based on the type of claim submitted.
    - Example: Frequency 7 entered in Box 22 of the CMS 1500 form.
    - Example: Frequency 7 used as the last digit for the bill type on a UB04 form (i.e. 1x7)
- The original claim number must also be listed on the corrected claim.
    - Box 22 on the CMS 1500 and box 64 on the UB04.

Claim Adjustments

A corrected claim can be submitted following IHCP claim adjustment processes.

A claim adjustment code is required on all claims, based on the type of claim submitted.

- Example: Frequency 7 entered in Box 22 of the CMS 1500 form.
- Example: Frequency 7 used as the last digit for the bill type on a UB04 form (i.e. 1x7)

The original claim number must also be listed on the corrected claim.

- Box 22 on the CMS 1500 and box 64 on the UB04.

Handwriting or stamping on a claim will not be accepted as submission of a corrected claim.

Correcting Claims

👪 After clicking on a Claim # link:

1. Click **Correct Claim.**
2. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
3. Continue clicking **Next** to move through the screens required to resubmit.
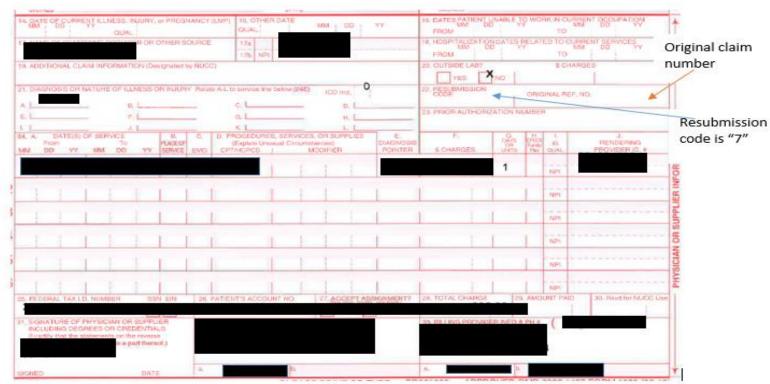4. Review the claim information.
5. Click **Submit**.

Back to Claims	Correct Claim	Copy Claim	Claim No.: Q180INE01235

Ref/Acct No.: P10007521700
Member ID: 1( )9
Member Name: [ ]Y
Member DOB: 1[ ]

Servicing Provider: SHAH, VINEET
Servicing NPI: 1699868455
DOS Range: 05/25/2017 - 05/25/2017

Received Date: 06/29/2017
Billed Amount: $99.00
Payment Amount: $0.00
Payment Date: 07/10/2017
Status: DENIED

LINE	DOS	PROC	DX	MODIFIERS	PLACE OF SERVICE	CHARGED	PAYMENT AMOUNT	PAYMENT DATE	CHECK NO.	STATUS	STATUS DESCRIPTION
1	05/25/2017	73110	S62101 A	TC, RT	11	$99.00	$0.00	07/10/2017	09004 13973	DENY	DUPLICATE CLAIMS OR MULTIPLE PROVIDERS BILLING SAME/SIMILAR CODE(S)

👪 Only claims with a status of **PAID** or **DENY**

👪 can be corrected online.

Claim Adjustments

- If you must submit via paper – never handwrite "corrected claim" on the claim form.

- Complete box 22 (Resubmission Code) to include a 7 (the "Replace" billing code) to notify us of a corrected or replacement claim.

Original claim number

Resubmission code is "7"

Prior Authorization

Authorization Considerations

- **Need to know what requires Authorization:**
    - Reference QRG
    - Pre-Authorization tool
- **How to obtain Authorization:**
    - Online (excluding Home Health and Hospice requests)
    - Phone
    - Fax
- **Authorizations do not guarantee payment**
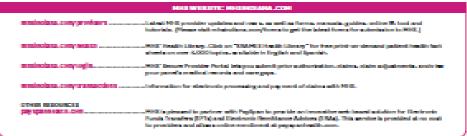
Prior Authorization

Is Prior Authorization Needed?

- MHS website: mhsindiana.com
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers

Prior Authorization

Some services that require prior authorization regardless of contract status (not inclusive) are:

- All elective hospital admissions
- All urgent and emergent hospital admissions (including NICU) require notice to MHS following the admission.
- Transition to hospice
- Newborn deliveries (Notification Required)
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Transition of care
- Transplants, including evaluations
- Physical Therapy, Occupational, and Speech Therapy

- Injectable drugs (see mhsindiana.com/provider-guides for up-to-date list of codes)
- Nutritional counseling (unless diabetic)
- Pain management programs, including epidural, facet and trigger point injections
- PET, MRI, MRA and Nuclear Cardiology/SPECT scans
- Cardiac rehabilitation
- Hearing aids and devices
- Home and Institutional hospice (coverage varies by product)
- In-home infusion therapy
- Orthopedic footwear
- Respiratory therapy services
- Pulmonary rehabilitation
- Home care (except after an IP admission with benefit limitations)

Reference QRG for a more detailed listing

Therapy Services
Speech, Occupational, Physical Therapy

- Benefit Limitations Apply
- Must follow billing guidelines
- Effective July 1, 2019, physical, occupational and speech therapy (PT, OT, and ST) services will no longer be managed through a post-service review process for MHS.

Prior authorization for PT, OT, and ST services will be required to determine whether services are medically necessary and appropriate. The utilization management of these services will continue to be managed by NIA.

- If requested, medical records can be uploaded to RadMD.com or faxed to NIA at 1-800-784-6864.
- Medical necessity appeals will be conducted by NIA:
  - Follow steps outlined in denial notification
  - NIA Customer Care Associates are available to assist providers at 1-866-904-5096

Claim appeals are handled by MHS.

- Providers are required to submit a request for appeal to the plan upon receipt of claim denial.

Imaging Prior Authorization Requests - NIA

- National Imaging Associates (NIA) manages non-emergent, advanced, outpatient imaging services to include prior authorization for MHS members

- The ordering physician is responsible for obtaining authorization

- To obtain authorization, go to the NIA website **RadMD.com** or through the NIA dedicated toll-free phone number, **1-866-904-5096**

- Failure to obtain PA may result in nonpayment of claim

- Emergency room, observation and inpatient imaging procedures do not require authorization

Turning Point Healthcare Solutions

- Effective 6/1/2019 Turning Point manages all prior authorizations for medical necessity and appropriate length of stay (when applicable) for musculoskeletal surgical procedures:

MUSCULOSKELETAL

Orthopedic Surgical Procedures
Including all associated partial, total, and revision surgeries

- ✓ Knee Arthroplasty
- ✓ Unicompartmental/Bicompartmental Knee Replacement
- ✓ Hip Arthroplasty
- ✓ Shoulder Arthroplasty
- ✓ Elbow Arthroplasty
- ✓ Ankle Arthroplasty
- ✓ Wrist Arthroplasty
- ✓ Acromioplasty and Rotator Cuff Repair
- ✓ Anterior Cruciate Ligament Repair
- ✓ Knee Arthroscopy
- ✓ Hip Resurfacing
- ✓ Meniscal Repair
- ✓ Hip Arthroscopy
- ✓ Femoroacetabular Arthroscopy
- ✓ Ankle Fusion
- ✓ Shoulder Fusion
- ✓ Wrist Fusion
- ✓ Osteochondral Defect Repair

Spinal Surgical Procedures
Including all associated partial, total, and revision surgeries

- ✓ Spinal Fusion Surgeries
  - ✓ Cervical
  - ✓ Lumbar
  - ✓ Thoracic
  - ✓ Sacral
  - ✓ Scoliosis
- ✓ Disc Replacement
- ✓ Laminectomy/Discectomy
- ✓ Kyphoplasty/Vertebroplasty
- ✓ Sacroiliac Joint Fusion
- ✓ Implantable Pain Pumps
- ✓ Spinal Cord Neurostimulator
- ✓ Spinal Decompression

Turning Point

- Emergency Related Procedures do not require authorization
- It is the responsibility of the ordering physician to obtain authorization
- Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims
- Clinical Policies are available by contacting TurningPoint at 1-574-784-1005 for access to digital copies

- TRAINING:
  - Informational webinars are available! Please register at: https://register.gotowebinar.com/rt/70795303694689722 90

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Turning Point's Utilization Management

Web Portal Intake:

- <u>myturningpoint-healthcare.com</u>

Telephonic Intake:

- 574-784-1005 | 855-415-7482

Facsimile Intake: 463-207-5864

Durable & Home Medical Equipment

- Members and referring providers do not need to search for a DME provider or provider of medical supplies to service their needs. Medline handles this for you.

- Order is submitted directly to MHS, through the Medline portal, unless PA is required, and delivered to the member

- **Web Portal**: Simply go to mhsindiana.com, log into the provider portal, and click on "Create Authorization." Choose DME and you will be directed to the **Medline** portal for order entry.

- Availability via Medline's web portal to submit orders and track delivery

- Prior authorization required by the ordering physician for all non-participating DME providers.

- Does not apply to items provided by and billed by physician office

- Exclusions applicable to specific hospital based DME/HME vendors

Behavioral Health Prior Authorization

- Prior Authorization
  - Please call Care Management for inpatient and partial hospitalization authorizations at 1-877-647-4848. Follow prompts to Behavioral Health.
  - Authorization forms may be obtained on our website
    - Outpatient Treatment Request (OTR) Form/Tip-Sheet/Training
    - Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency
    - Applied Behavioral Analysis Treatment
    - Psychological Testing Authorization Request Form (Outpatient & Inpatient)
- Medical Necessity Appeals
  - Submit to:
    MHS Behavioral Health
    ATTN: Appeals Coordinator
    12515-8 Research Blvd, Suite 400
    Austin, TX 78759

Behavioral Health Services Requiring Authorization
Professional Services

- Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month Rolling year without authorizaton)
- Electroconvulsive Therapy
- Psychological Testing (Unless for Autism: then no auth is required)
- Developmental Testing, with interpretation and report (non-Early Periodic Screening, Diagnosis Treatment EPSDT)
- Neurobehavioral status exam, with interpretation and report
- Neuropsych Testing per hour (face to face) (Unless for Autism: then no auth is required). (Non-Participating Providers only)
- Applied Behavioral Analysis (ABA) Services

Clinical Laboratory Improvement Amendments (CLIA)

All providers that bill laboratory services on a **CMS-1500** form must have CLIA certification or a CLIA waiver certification equal to the procedure code being billed.

EXc1 DENIED: INVALID CLIA NUMBER:
- This verification will ensure that MHS is compliant with the CMS guidelines.

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Dispute Resolution Process

Dispute Resolution/Appeals

- Must be made in writing by using the MHS informal claim dispute/objection form, available at mhsindiana.com/provider-forms.
- Submit all documentation supporting your objection.
- Send to MHS within **67 calendar days** of receipt of the MHS EOP. *Please reference the original claim number*. Requests received after day 67 will not be considered*.

Medical Claims:	**Behavioral Claims**:
MHS Medical Appeals	MHS BH Appeals
Attn: Appeals	Attn: Appeals Department
P.O. Box 3000	P.O. Box 6000
Farmington, MO 63640-3800	Farmington, MO 63640-3809

- MHS will acknowledge your appeal within 5 business days.
- Provider will receive notice of determination within 45 calendar days of the receipt of the appeal.

A call to MHS Provider Services does not reserve appeal rights

Dispute Resolution/Appeals

Level One Appeal- Claim Objection

- Must be made in writing by using the MHS informal claim dispute/objection form.

- Submit all documentation supporting your objection.

- Send to MHS within 67 calendar days of receipt of the original MHS EOP.

- Provider should proceed with level two appeal, if claim has not been overturned 30 days from initial objection submission.

A call to MHS Provider Services does not reserve appeal rights

Dispute Resolution/Appeals

Level Two Appeal (Administrative):

- If you disagree with your level one decision:
- Submit the informal claims dispute or objection form with all supporting documentation to the MHS appeals address:

Managed Health Services
Attn: Appeals
P.O. Box 3000
Farmington, MO 63640-3800

- MHS will acknowledge your appeal within 5 business days.
- Provider will receive notice of determination within 45 calendar days of the receipt of the appeal.

Portal Functionality

Secure Web Portal Login or Registration

Login/Register is the same for **MHS**, **Ambetter from MHS, Allwell from MHS** and **Behavioral Health** Providers

Web Portal Training Documents

Documents Include:
- Registration Guide
- MHS Web Portal User Guides
- How To Complete Specific Tasks on the MHS Web Portal

FOR PROVIDERS

Login

Enrollment and Updates
Prior Authorization ⊕
Dental Providers
Pharmacy ⊕
Opioid Resources
Behavioral Health ⊕
Provider Resources ⊕
QI Program ⊕
Provider News
Email Sign Up

PORTAL TRAINING GUIDES ⊖
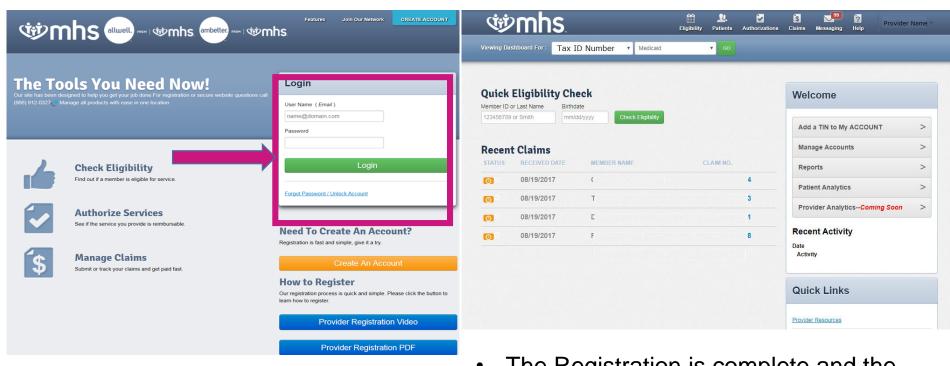
- Account Manager User Guide (PDF)
- Provider Secure Portal Brochure (PDF)
- Provider Secure Portal Flyer (PDF)
- Submit a Claim CMS 1500 (PDF)
- Submit a Claim CMS UB-04 (PDF)
- Submit a Corrected Claim (PDF)
- Update Portal Account Details (PDF).
- Utilize Member Management Forms (PDF).
- View Claim Status (PDF)
- View Payment History (PDF)
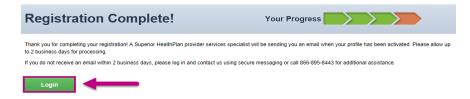
Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our Become a Provider page to get started. For further assistance, you can call Provider Services at 1-877-647-4848 or see our Account Registration Guide (PDF).

Complete Registration or Login

- The Registration is complete and the Secure Portal homepage will be visible!

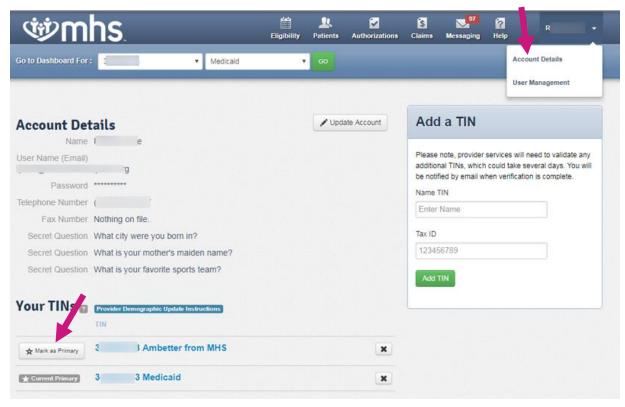- An email will be sent to the provider when they have access to specific tools.

Account Details
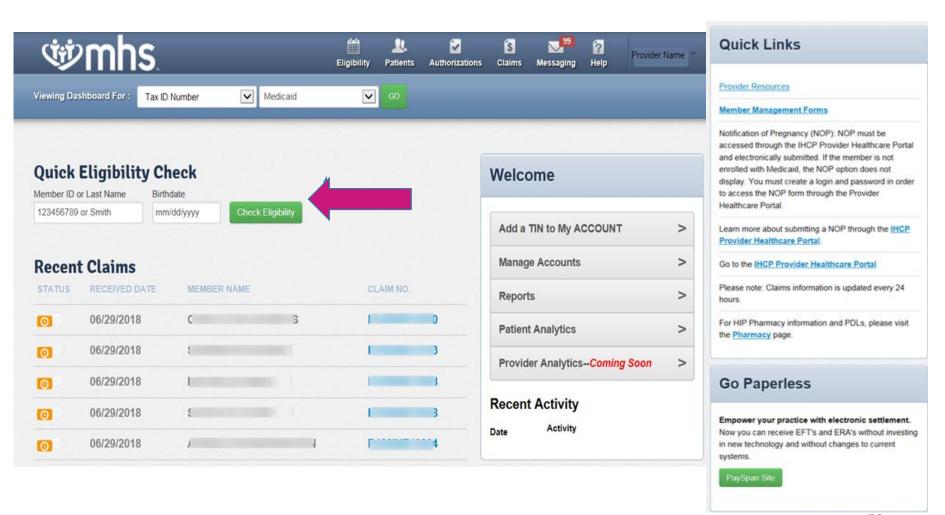
👥 **To view your Account Details:**

1. Select the **drop-down arrow** next to user name in the upper right corner on the dashboard.
2. Click **Account Details.**

Note: Under Your TINs you see the Current **Primary** Default TIN for the account, and can select another TIN to **Mark As Default** or **Remove** a TIN.
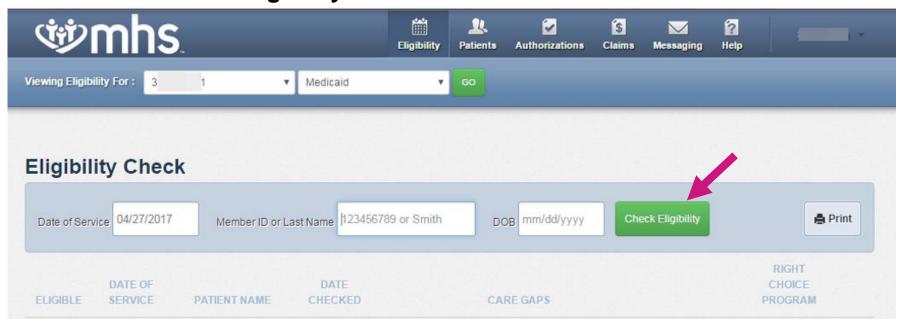
Homepage – MHS (Medicaid)

Check Eligibility
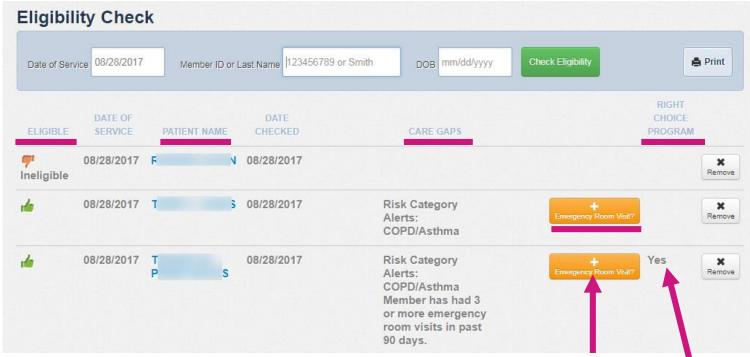
The **Eligibility** tab offers an **Eligibility Check** tool designed to quickly check the status of any member:
- Update the **Date of Service,** if necessary.
- Enter the **Member ID** or **Last Name** and **DOB (Date of Birth)**
- Click **Check Eligibility.**

Check Eligibility

Eligibility status is indicated by a Green Thumbs-Up for **Eligible** and an Orange Thumbs-Down for **Ineligible.**

Details for any member can be viewed by clicking on the **Member's Name**.

Care Gaps can also be seen within the search results.

By clicking **Emergency Room Visit?**, an ER visit will be indicated.

Right Choice Program indicator labeled **Yes**

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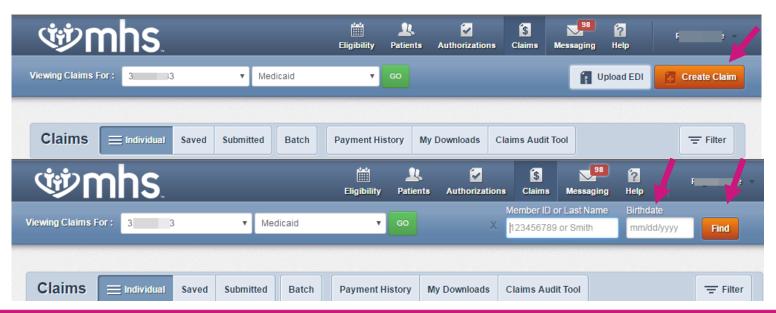
Claims

![mhs logo] **Web Portal Claims Functionalities:**
- **Submit** new claim.
- **Review claims** information on file for a patient.
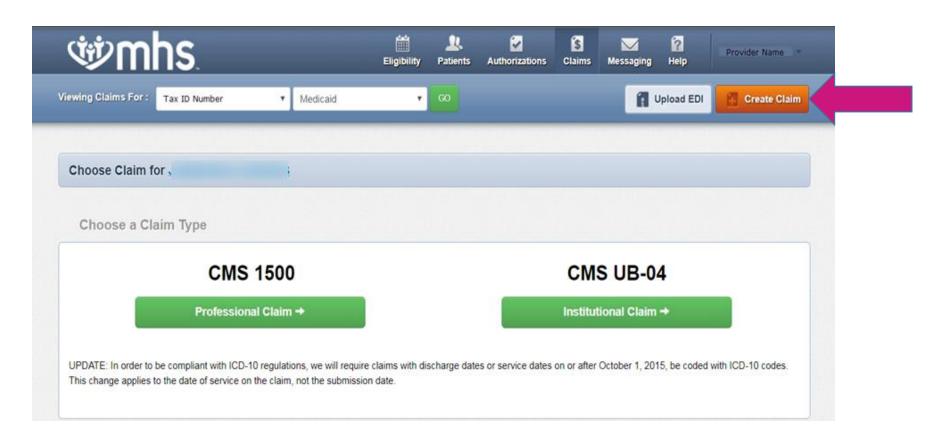- **Correct** claims.
- **View payment history.**

![mhs logo] **Submit a New Claim:**
- Click **Create Claim** and enter **Member ID** and **Birthdate**

Claim Submission

- Choose the **Claim Type**
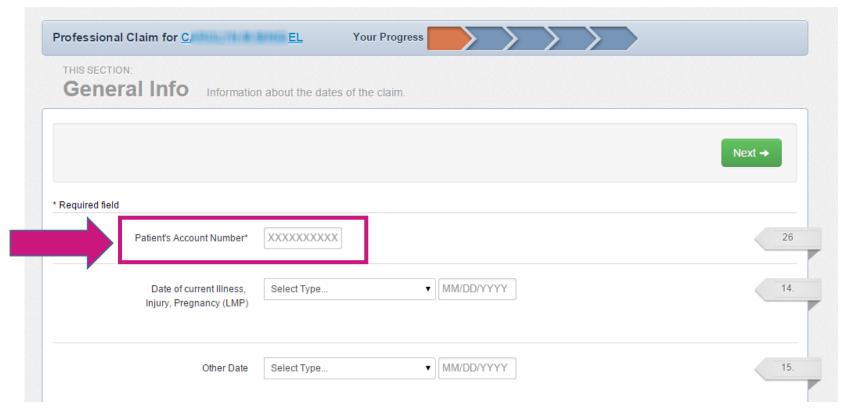 - **Professional** or **Institutional** claim submission

Professional Billing
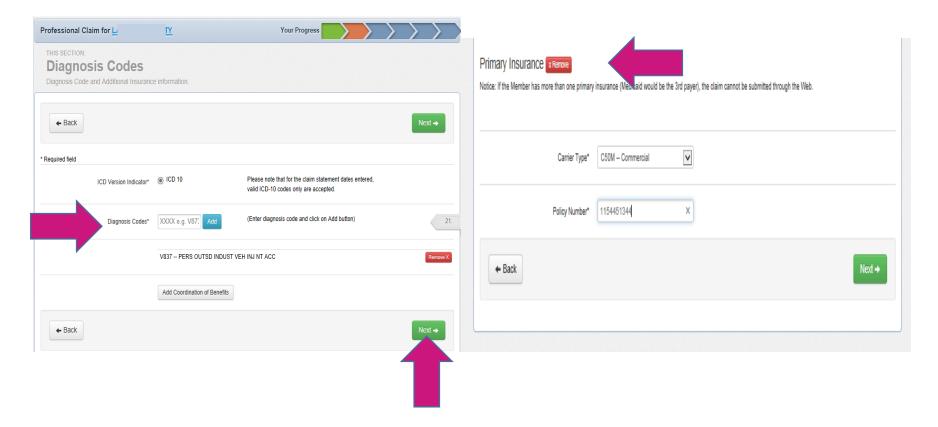
Professional Claim Submission: Step 1

- In the **General Info** section, populate the **Patient's Account Number** and other information related to the patient's condition by typing into the appropriate fields.
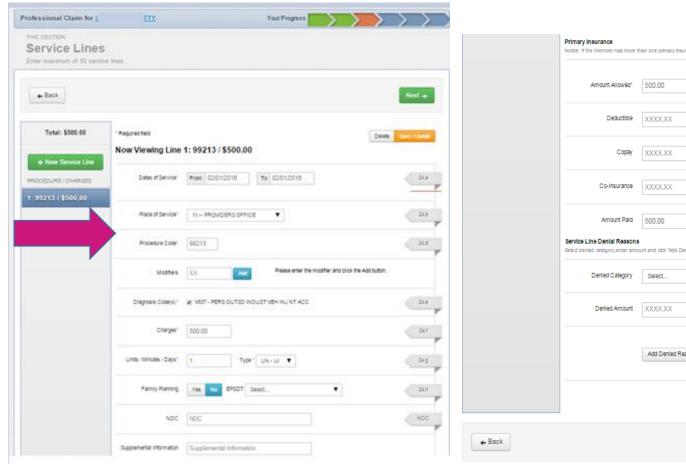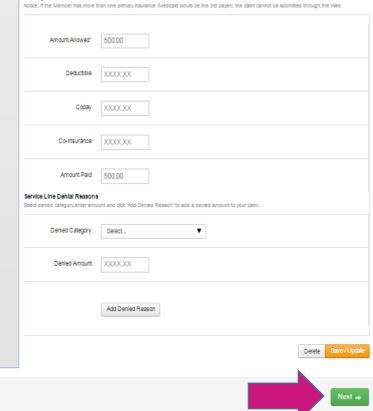- Click **Next**.

Professional Claim Submission: Step 2

- Add the **Diagnosis Codes** for the patient in Box 21.
- Click the **Add** button to save.

- Click **Add Coordination of Benefits** to include any payments made by another insurance carrier (if applicable).
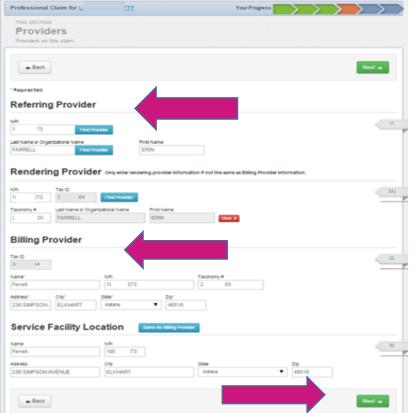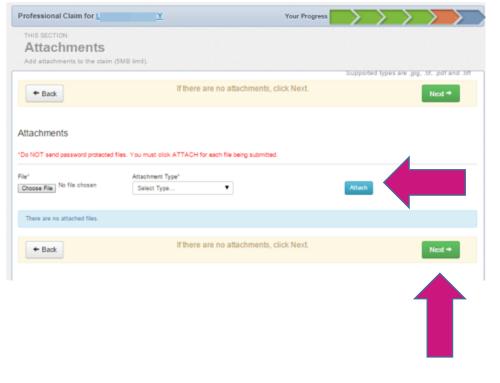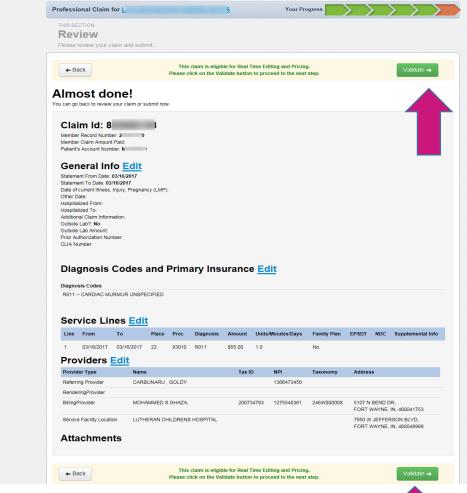
Professional Claim Submission: Step 3

Add **Service Lines.**

Professional Claim Submission: Step 4 - 5

- Enter **Referring** and **Billing Provider** information. Enter **Service Facility Location**.
- Click **Next**.

- In the Attachments section you can **Browse** and **Attach** any documents to the claim as desired. (Note: If you have no attachments, skip this section.)
- Click **Next**.

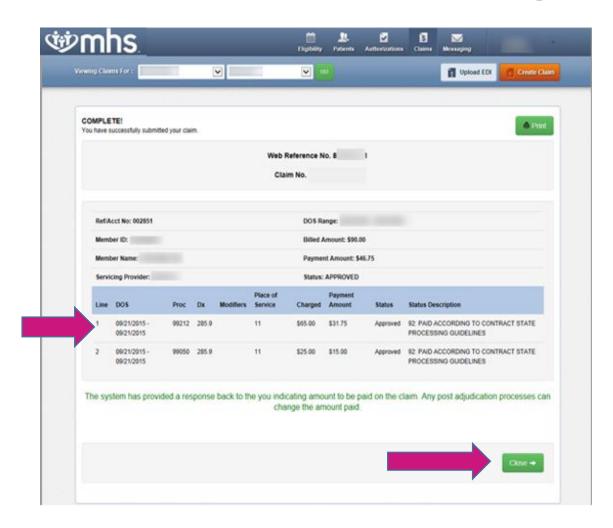# Professional Claim Submission: Step 6

- In the **Review** section, you can see if the claim is eligible for Real Time Editing and Pricing (RTEP).

- Click **Validate** for RTEP Claims and Click **Submit** for regular processed claims.

RTEP Claim Pricing View

ᐁᐃ RTEP Overview:

- On the final screen, each procedure code will receive a reimbursement estimate, pending claim explanation or denial reason.
- Claims with a reimbursement estimate or pend explanation, may be impacted by final adjudication including a change to the reimbursement amount or a denial.
- Adjudication status may be affected by Code Editing or other payment rules.
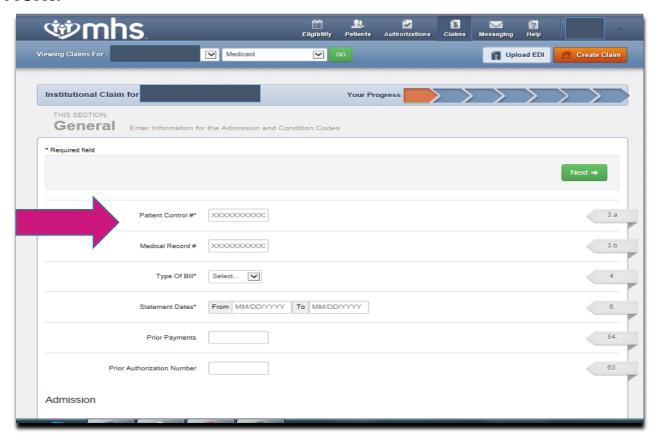
Facility Billing

UB-04 Billing
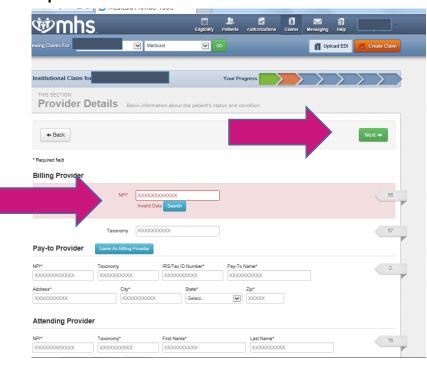
In the **General Info** section, populate the **Patient's Control Number** and other information related to the patient's condition by typing into the appropriate fields.

Click **Next**.

UB Billing

- Add the **provider information.**
- Click **save** and click **next** to proceed
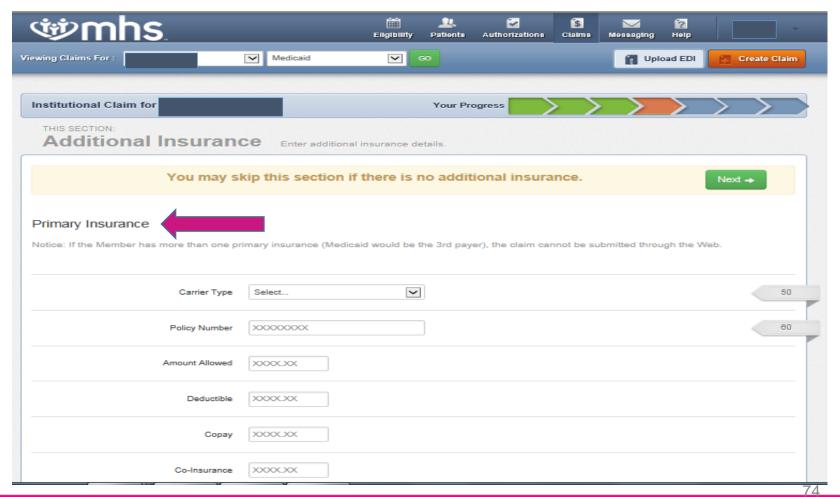
- Click **Add New Service Line** and enter the service lines information.
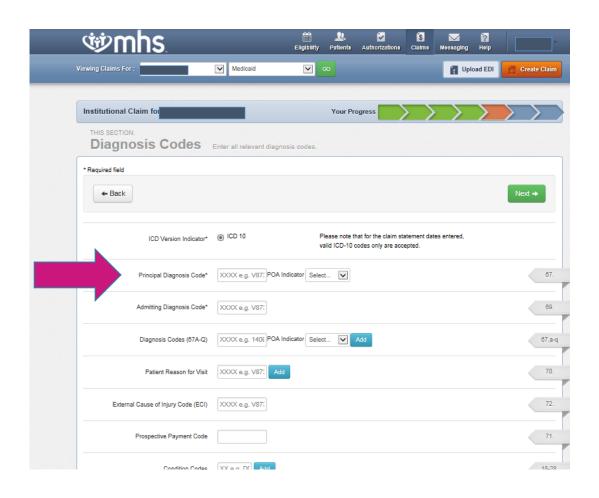
Enter Additional Insurance (if applicable)
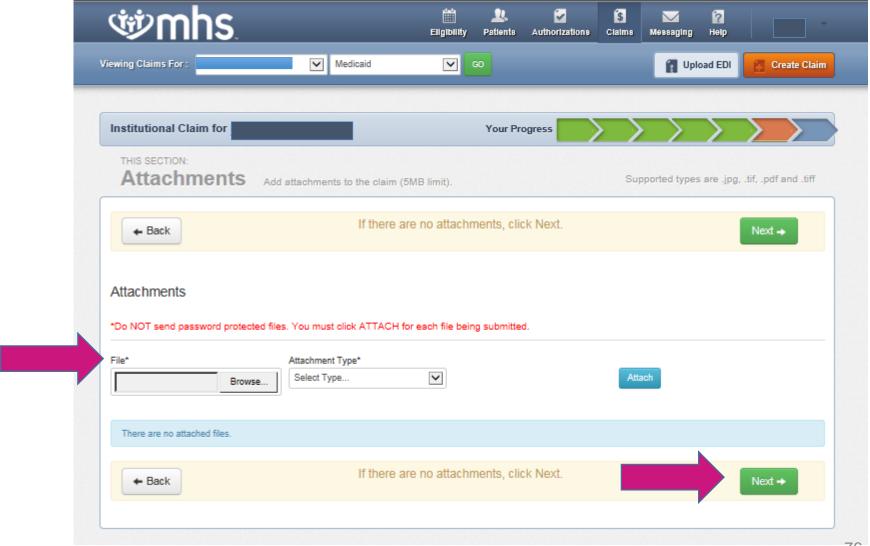
Enter Diagnosis Codes (use Add button)

Add Attachments (if applicable)

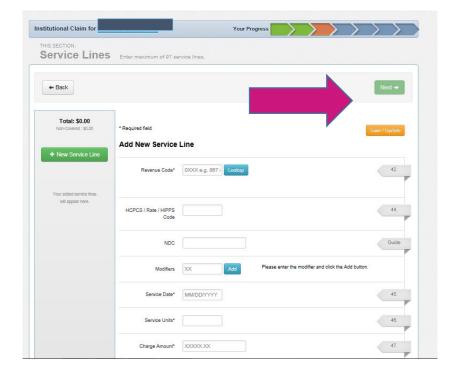# Review Claim and Submit
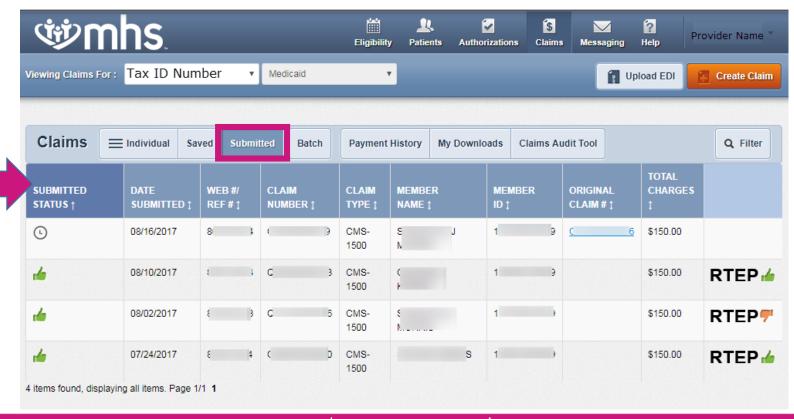
Web Portal Claim and Payment Review

Submitted Claims
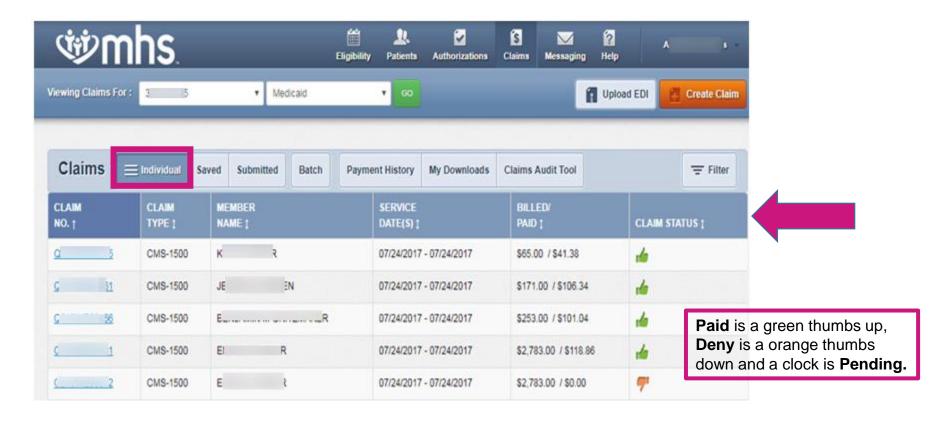
The **Submitted** tab will only display claims created via the MHS portal:
- **Paid** is a green thumbs up.
- **Denied** is an orange thumbs down.
- **Pending** is a clock.

RTEP claims also show if eligible (i.e. line 3 was submitted, but was not eligible for RTEP).

Individual Claims
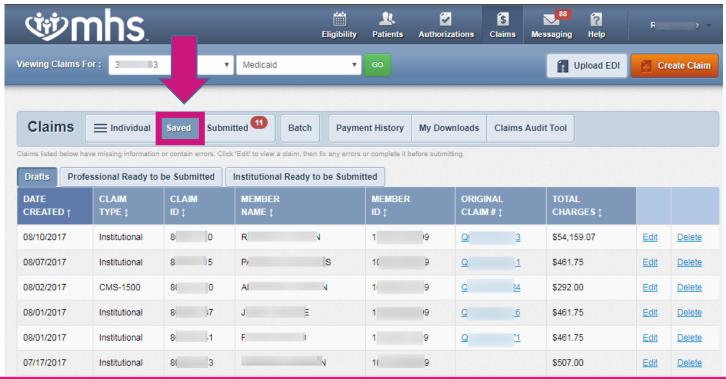
On the **Individual** tab, submitted using paper, portal or clearing house:

- View the Claim No, Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status

Paid is a green thumbs up, **Deny** is a orange thumbs down and a clock is **Pending.**

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Saved Claims

To view **Saved** claims: Drafts, Professional or Institutional:
1. Select **Saved.**
2. Click **Edit** to view a claim.
3. Fix any errors or complete before submitting.
   Or
4. Click **Delete** to delete saved claim that is no longer necessary.
5. Click **OK** to confirm the deletion.

Correcting Claims

After clicking on a **Claim #** link:

1. Click **Correct Claim.**
2. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
3. Continue clicking **Next** to move through the screens required to resubmit.
4. Review the claim information.
5. Click **Submit.**

Only claims with a status of **PAID** or **DENY** can be corrected online.

Payment History

Click on **Payment History** to view Check Date, Check Number, Check Clear Date, Mailing Address and Payment Amount

- Click on **Check Date** to view Explanation of Payment

Payment History

Click on **View Service Line Details.**
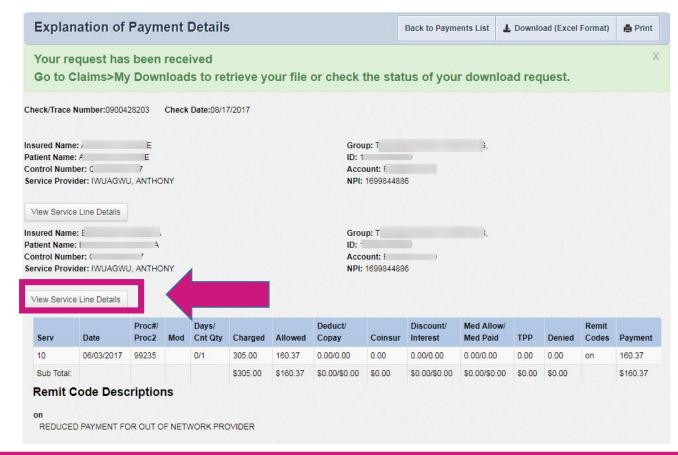
Payment History
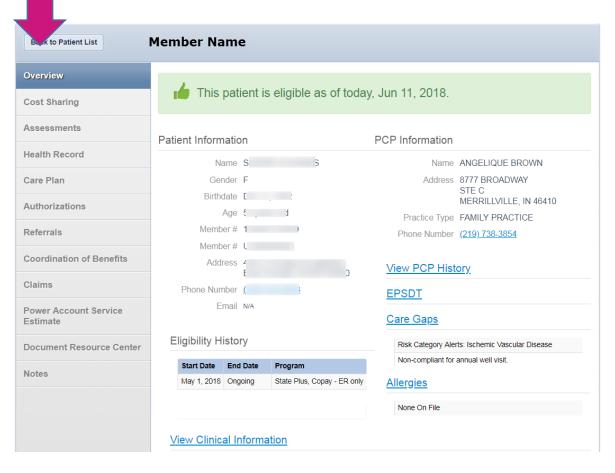
View **Service Line Details:**

- The **Explanation of Payment Details** displays the Date and Check Number/Trace number.
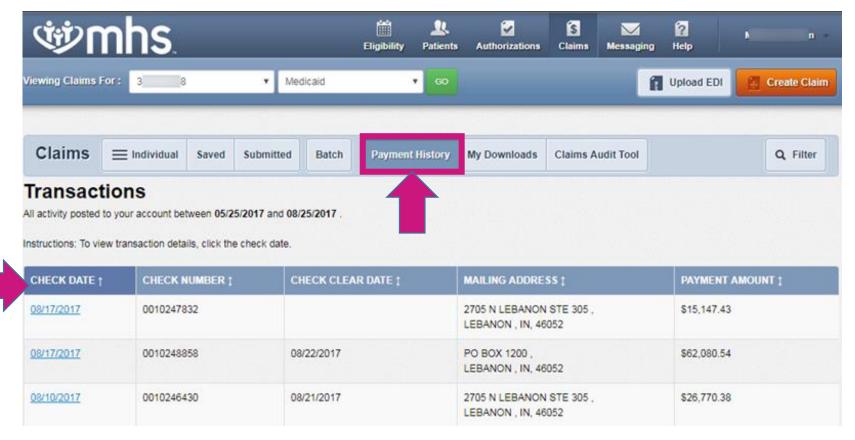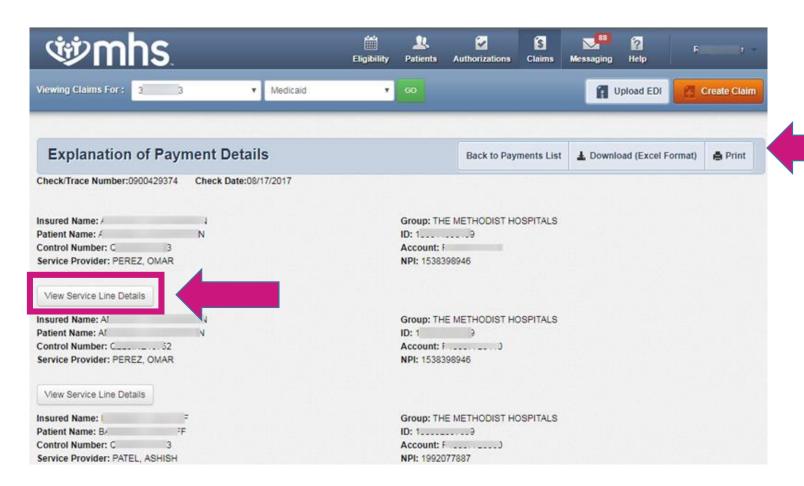- This view shows each patient payment by service line detail made on the check.

Explanation of Payment Details   Back to Payments List   ⬇ Download (Excel Format)   🖨 Print

> **Your request has been received**
> Go to Claims>My Downloads to retrieve your file or check the status of your download request.   X

Check/Trace Number:0900428203   Check Date:08/17/2017

Insured Name: A_____E   Group: T_____S,
Patient Name: A_____E   ID: 1_____
Control Number: C_____7   Account: F_____
Service Provider: IWUAGWU, ANTHONY   NPI: 1699844886

[View Service Line Details]

Insured Name: B_____   Group: T_____S,
Patient Name: I_____A   ID: 1_____
Control Number: C_____7   Account: F_____
Service Provider: IWUAGWU, ANTHONY   NPI: 1699844886

[View Service Line Details]

Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	06/03/2017	99235		0/1	305.00	160.37	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	on	160.37
Sub Total:					$305.00	$160.37	$0.00/$0.00	$0.00	$0.00/$0.00	$0.00/$0.00	$0.00	$0.00		$160.37

Remit Code Descriptions

on
   REDUCED PAYMENT FOR OUT OF NETWORK PROVIDER

Member Overview

Overview Tab
1. Patient Information
2. Eligibility History
3. PCP Information and PCP History
4. EPSDT
5. Care Gaps
6. Allergies

Cost Sharing

Cost Sharing shows if a member has any co-payments.
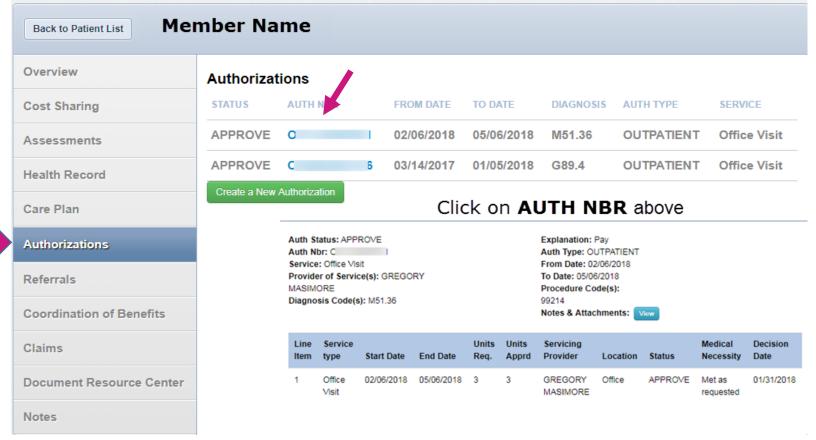
Back to Patient List	Member Name

Overview
Cost Sharing
Assessments
Health Record
Care Plan
Authorizations
Referrals
Coordination of Benefits
Claims
Power Account Service Estimate
Document Resource Center
Notes

HIP BASIC MEMBER COST SHARING GRID	
Type of Service	**Co-Pay Amount**
Preventive Care	No co-pay
Family Planning Services	No co-pay
Outpatient Services	$4.00
Inpatient Services	$75.00
Preferred Drugs	$4.00
Non-Preferred Drugs	$8.00

*MHS will not collect POWER Account contributions or impose any other cost-sharing, including co-pays for non-urgent care use of hospital emergency departments, on members who are pregnant or Native American Indian.

NON-EMERGENCY USE OF AN EMERGENCY ROOM CO-PAYS	
# of Non-Emergency Emergency Room Visits	**Co-Pay Amount**
Each Visit	$8.00

*Co-pays for non-emergency use of an emergency room will be collected by all eligible HIP member EXCEPT for those exempt from cost-sharing (pregnancy or Native American Indian).
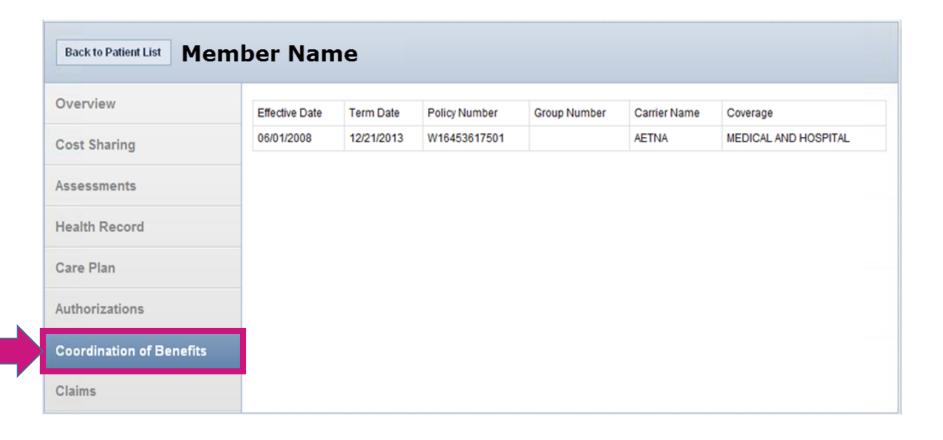
Authorizations

View previously submitted or **Create a New Authorization.**

Coordination of Benefits
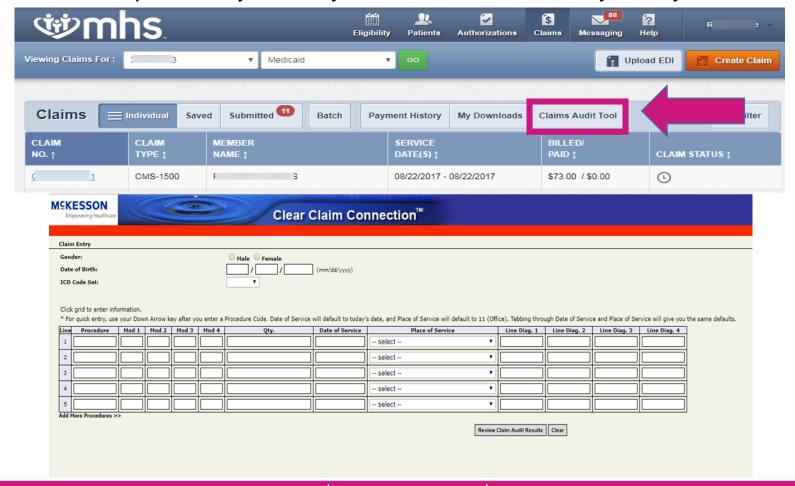
This screen shows if a member has other insurance.

Back to Patient List	**Member Name**					
Overview	Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
Cost Sharing	06/01/2008	12/21/2013	W16453617501		AETNA	MEDICAL AND HOSPITAL
Assessments						
Health Record						
Care Plan						
Authorizations						
Coordination of Benefits						
Claims						

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Claims Audit Tool

The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit .

Tips to Remember

- Clicking on items (claim numbers, check numbers, dates) that are highlighted blue will reveal additional information.

- When **filtering** to find a claim or payment, only a **1 month** span can be used.

- Click on the **Saved Claims** tab to view claims that have been created but not Submitted. Claims in this queue can be edited for submission or deleted from this tab.

- In order to utilize the **Correct Claim** feature, the claim needs to be in a **Paid** or **Denied** status.

- When filtering **Payment History** the span is limited to 1 month.

MHS Team

mhs

MHS Provider Network Territories

Indiana

NORTHEAST REGION
Claims Issues: MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848 ext. 20454
ripratt@mhsindiana.com

CENTRAL REGION
Claims Issues: MHS_ProviderRelations_C@mhsindiana.com
Esther Cervantes, Provider Partnership Associate
1-877-647-4848 ext. 20947
Estherling.A.PimentelCervantes@mhsindiana.com

NORTHWEST REGION
Claims Issues: MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848 ext. 20187
Candace.V.Ervin@mhsindiana.com

SOUTHWEST REGION
Claims Issues: MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848 ext. 20117
Dawnalee.A.McCarty@mhsindiana.com

SOUTHEAST REGION
Claims Issues: MHS_ProviderRelations_SE@mhsindiana.com
1-877-647-4848

NETWORK LEADERSHIP

Jill Claypool
Vice President, Network
Development & Contracting
1-877-647-4848 ext. 20855
jill.e.claypool@mhsindiana.com

Nancy Robinson
Senior Director, Provider Network
1-877-647-4848 ext. 20180
nrobinson@mhsindiana.com

Mark Vonderheit
Director, Provider Network
1-877-647-4848 Ext. 20240
mvonderheit@mhsindiana.com

NEW PROVIDER CONTRACTING

Tim Balko
Director, Network Development & Contracting
1-877-647-4848 ext. 20120
tbalko@mhsindiana.com

Michael Funk
Manager, Network Development & Contracting
1-877-647-4848 ext. 20017
michael.j.funk@mhsindiana.com

NETWORK OPERATIONS

Kelvin Orr
Director, Network Operations
1-877-647-4848 ext. 20049
kelvin.d.orr@mhsindiana.com

mhs

MHS Provider Network Territories

TAWANNA DANZIE
Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com

PROVIDER GROUPS
Beacon Medical Group
Community Care Network
Franciscan Alliance
Goshen Health System
HealthLinc
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Northshore Health Centers
Parkview Health System
South Bend Clinic

JENNIFER GARNER
Provider Partnership Associate II
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS
American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
Good Samaritan Hospital Physician Services
HealthNet
Health & Hospital Corporation of Marion County
Indiana University Health
Little Company of Mary Hospital of Indiana
Riverview Hospital
St. Vincent Medical Group

INTERNAL REPRESENTATIVES

JENNIFER DEAN
Provider Network Specialist
1-877-647-4848 ext. 20221
jedean@mhsindiana.com

LAKISHA BROWDER
Provider Relations Specialist
1-877-647-4848 ext. 20224
lbrowder@mhsindiana.com

ENVOLVE DENTAL, INC.
MICHAEL J. WILLIAMS
Provider Relations Specialist
1-727-437-1832
Dental Provider Services: 1-855-609-5157
Michael.Williams@EnvolveHealth.com

Summary

We hope you learned more about the following topics:

- Ease of claim submission with MHS
- How to timely submit claim adjustments electronically
- Tips on how to successfully problem solve claim rejections
- Steps for researching claim denial issues
- How to effectively navigate the MHS Portal
- Details about Dispute Resolution process
- Who to contact for assistance at MHS

Session Survey – Tuesday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1012

Session Survey – Thursday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1034